BEFORE THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS

IN MEDICINE AND SURGERY

IN THE MATTER OF: **RICK SHACKET D.O.** Holder of License No. **4257** For the practice of osteopathic medicine in the State of Arizona	**Case Nos.: DO-16-0137A** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER FOR DECREE OF CENSURE AND CIVIL PENALTY**

In June 2016, the Arizona Board of Osteopathic Examiners (hereafter "Board") received a complaint from a healthcare provider who treated the patient, A.R., at a hospital after A.R. suffered a seizure and had severe cerebral edema necessitating EVD placement and debulking. It was determined that A.R. had been receiving treatment at EuroMed under the supervision of Rick Shacket, D.O. (herein after "Respondent").

The Board duly noticed an Investigative Hearing on this matter for April 1, 2017, which was continued to May 6, 2017, at Respondent's request. On May 6, 2017, Respondent appeared personally and with counsel, Mr. Douglas Guffey for the Investigative Hearing.

After hearing testimony from the Respondent and his witness, Elliot Schmerler, and considering the documents and evidence submitted, the Board voted to enter the following Findings of Fact, Conclusions of Law, and Order for a Decree of Censure.

JURISDICTIONAL STATEMENTS

1. The Board is empowered, pursuant to A.R.S. § 32-1800 *et seq.*, to regulate the practice of osteopathic medicine in the State of Arizona, and the conduct of the persons licensed, registered, or permitted to practice osteopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 4257 issued by the Board for the practice of osteopathic medicine in the State of Arizona.

FINDINGS OF FACT

3. On April 19, 2016, A.R., a thirty-three year old female with a large inoperable glioblastoma multiforme (GBM) diagnosed in December 2015, presented to EuroMed in Scottsdale, Arizona for "alternative cancer therapy." She was administered a high dose Vitamin C, other homeopathic remedies, and Insulin potentiation therapy ("IPT") with conventional chemotherapy given intravenously twice weekly by various individuals at EuroMed who were under the Respondent's supervision. The medical records do not demonstrate that Respondent took a history from A.R., examined or evaluated A.R., or that he wrote orders signing off on the treatment provided to A.R. The standard of care would have been for the Respondent to document in the medical record the results of a physical examination and history.

4. Respondent obtained post graduate training by completing one year in family practice and two years in a proctology residency. He did not receive training in oncology and admits he practices proctology 95% of the time at his own practice. Respondent admitted he was responsible for the IPT and chemotherapy administered to A.R., but the records did not indicate he signed off on the dosages given or the combinations of medications administered. The standard of care requires the Respondent signing off in the medical record for the chemotherapy doses and combinations or medications used.

5. Respondent's conduct has harmed or may endanger the public's health or was reasonably expected to do so. Respondent lacked the proper training and background to provide chemotherapy to a patient who was terminally ill. A.R. was charged $1,700.00 twice a week for treatment, including IPT. There have been no conclusive studies performed to confirm the reproducible benefit of IPT or the efficacy of IPT to conventional chemotherapy. Respondent's conduct fell below the standard of care in that osteopathic medicine is based upon evidence-based treatment approaches. This patient should have been referred to hospice.

There were concerns about the treatment, which was very expensive but had no effect in terms of the tumor regression and potential side effects of the medications administered.

6. Respondent admitted that formal oncology is best for his proctology patients and if one of his proctology patients has cancer, he would refer them to an oncologist for treatment. The medications administered in IPT could be considered highly toxic and the prescriber of such medications should have knowledge in the medications being administered as well as the effects and possible side effects of each and the basis for the use of each. Evidence to support Respondent's knowledge of these medications was not provided.

7. Consent forms provided to the patient are inadequate in that they do not provide a list of potential side-effects of the drugs being administered. The standard of care requires the consent form to adequately describe the side effects of the six chemotherapeutic agents used. The consent forms in this matter did not properly describe the effects or possible side effects of these drugs.

8. The medical record does not indicate that Respondent collaborated with the PA and/or medical assistants (office personnel) regarding physical examination and treatment of the patient. The examinations were allegedly performed by the PA and the IPT treatments were administered by Medical Assistants without Respondent's supervision or any other person that Respondent may supervise. Appropriate supervision of the examination or the administration of IV drugs is a standard of care that was not met.

9. Respondent failed to adequately supervise those who were examining and treating the patient. The standard of care would be for the supervising physician to oversee and authorize the medications administered to the patient after conducting a physical and history.

10. While under the care of Respondent, A.R. decreased her Dexamethasone, which had been prescribed by her prior Oncologist for brain swelling. As a result of this decrease in

the medication, A.R. had seizures and required hospitalization on May 6, 2016. Her last treatment with EuroMed was on May 6, 2016.

CONCLUSIONS OF LAW

11. The conduct described above is a violation of unprofessional conduct pursuant to A.R.S. § 32-1854 (6), which states "Engaging in the practice of medicine in a manner that harms or may harm a patient or that the board determines falls below the community standard.

12. The conduct described above is a violation of unprofessional conduct pursuant to A.R.S. § 32-1854(38), which states "Any conduct or practice that endangers the public's health or may reasonably be expected to do so."

13. The conduct described above is a violation of unprofessional conduct pursuant to A.R.S. § 32-1854 (34), which states "Lack of or inappropriate direction, collaboration or supervision of a licensed, certified or registered health care provider or office personnel employed by or assigned to the physician in the medical care of patients. "

ORDER

Pursuant to the authority vested in the Board,

1. **IT IS HEREBY ORDERED** that the license of Rick Shacket, D.O, holder of osteopathic medical License number 4257 is issued a **DECREE OF CENSURE**.

2. **IT IS FURTHER ORDERED** that Respondent shall pay a one thousand dollar ($1,000.00) Civil Penalty to the Arizona Board of Osteopathic Examiners in Medicine and Surgery within thirty (30) days of the effective date of this Order. The effective date of this Order is thirty-five days after it is mailed to Respondent.

ISSUED THIS 8th DAY OF JUNE, 2017.
ARIZONA BOARD OF OSTEOPATHIC EXAMINERS
IN MEDICINE AND SURGERY

By: _____
Jenna Jones, Executive Director

NOTICE OF RIGHT TO REQUEST REVIEW OR REHEARING

Any party may request a rehearing or review of this matter pursuant to A.R.S. § 41-1092.09. The motion for rehearing or review must be filed with the Arizona Board of Osteopathic Examiners within thirty (30) days. If a party files a motion for review or rehearing, that motion must be based on at least one of the eight grounds for review or rehearing that are required under A.A.C. R4-22-108(D). Failure to file a motion for rehearing or review within 30 days has the effect of prohibiting judicial review of the Board's decision. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Original "Findings of Fact, Conclusions of Law and Order for Decree of Censure and Civil Penalty" filed this 8th day of June, 2017 with:

Arizona Board of Osteopathic Examiners
In Medicine and Surgery
9535 East Doubletree Ranch Road
Scottsdale AZ 85258-5539

Copy of the "Finding of Fact, Conclusions of Law and Order for Decree of Censure and Civil Penalty" sent by regular mail this 8th day of June, 2017 to:

Douglas Guffey, Esq.
Jaburg and Wilk
3200 N. Central Avenue, 20th Floor
Phoenix, AZ 85012

Copies of this "Findings of Fact, Conclusions of Law and Order for Decree of Censure and Civil Penalty" sent by certified mail, return receipt requested this 8th day of June, 2017 to:

Rick Shacket, D.O.
Address of Record

and

Jeanne Galvin, AAG
Office of the Attorney General SGD/LES
1275 West Washington
Phoenix AZ 85007